ATTENDING DENTIST'S STATEMENT

Carrier name and address

EDS
PO BOX 244033
MONTGOMERY AL 36124-4033

☐ Dentist's pre-treatment estimate

☒ Dentist's statement of actual services

1. Patient name (first / m.i. / last)	2. Relationship to employee	3. Sex (m / f)	4. Patient birthdate (MM DD YY)	5. If full time student (school / city)
Jane A Doe	☐ self ☒ child ☐ spouse ☐ other	x	12 15 89	

6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate (MM DD YY)	9. Employer (company) name and address	10. Group number
Jane A. Doe 100 Mayfair Lane Anywhere AL 30000	0001234567890			

11. Is patient covered by another dental plan?	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of other employer(s)
☐ yes ☒ no If yes, complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no			

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate (MM DD YY)	15. Relationship to patient
			☐ self ☐ parent ☐ spouse ☐ other

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▸ Signature on File — Signed (Patient, or parent if minor) — 10-21-99 Date

I hereby authorize payment of dental benefits otherwise payable to me directly to the below named dental entity.

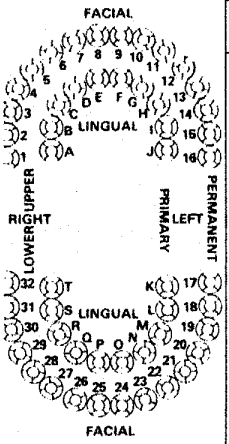
▸ Signature on File — Signed (Insured person) — 10-21-99 Date

16. Name of Billing Dentist or Dental Entity	17. Address where payment should be remitted (City, State, Zip)	18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.
Anywhere Dental Clinic	2000 Maplewood Land Anywhere AL 30000	630000000		(334)123-4567

	No	Yes	If yes, enter brief description and dates.
24. Is treatment result of occupational illness or injury?	x		
25. Is treatment result of auto accident?	x		
26. Other accident?	x		
27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
29. Is treatment for orthodontics?	x		If services already commenced enter: Date appliances placed Mos. treatment remaining

21. First visit date current series	22. Place of treatment (Office / Hosp. / ECF / Other)	23. Radiographs or models enclosed? (No. / Yes / How many?)
	11	x

Identify missing teeth with "x"



30. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use chart system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only
		Exam-Comprehensive	093099	00150	38 00	000012345
		Bite Wings-Two Films	093099	00272	16 00	000012345

SAMPLE CLAIM

WHEN THE PERFORMING PROVIDER AND THE BILLING PROVIDER NUMBERS ARE DIFFERENT.

For complete claim filing details see Chapter 5 of *the Alabama Medicaid Provider Manual.*

For dental program specific information see Chapter 13 of the *Alabama Medicaid Provider Manual.*

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▸ John Smith — Signed (Treating Dentist) — 521234567 License Number — 10-21-99 Date

Total Fee Charged	54 00
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Form Approved by the Council on Dental Care Programs **AMERICAN DENTAL ASSOCIATION**